GAMBLING DISORDER & SUICIDAL BEHAVIOR IN THE VETERAN POPULATION

- Herman Diggs, Ph.D.
- Arizona Department of Gaming
- 14th Annual Problem Gambling Symposium
- Phoenix, AZ
- 03/02/2020

DISCLOSURE

- Though this presentation is based partly on research supported by the Department of Veterans Affairs, it does not represent the view of the Department of Veterans Affairs or the United States Government
- The presenter has no financial investments with any of the treatment modalities or research discussed in this presentation

MYTH OR FACT??

Asking directly about suicide is likely to plant the idea in someone's head, especially if they are already in distress.

Asking about suicide does not initiate these thoughts. It allows the person the permission to talk honestly about what they are going through.

MYTH OR FACT??

When it comes to suicide, there are talkers, and there are doers.

Most suicidal behavior has been communicated prior to the act. Someone who talks about suicide gives others the opportunity to intervene.

MYTH OR FACT??

People that have upcoming plans or have signed a no suicide contract are much less likely to follow through with suicidal behavior.

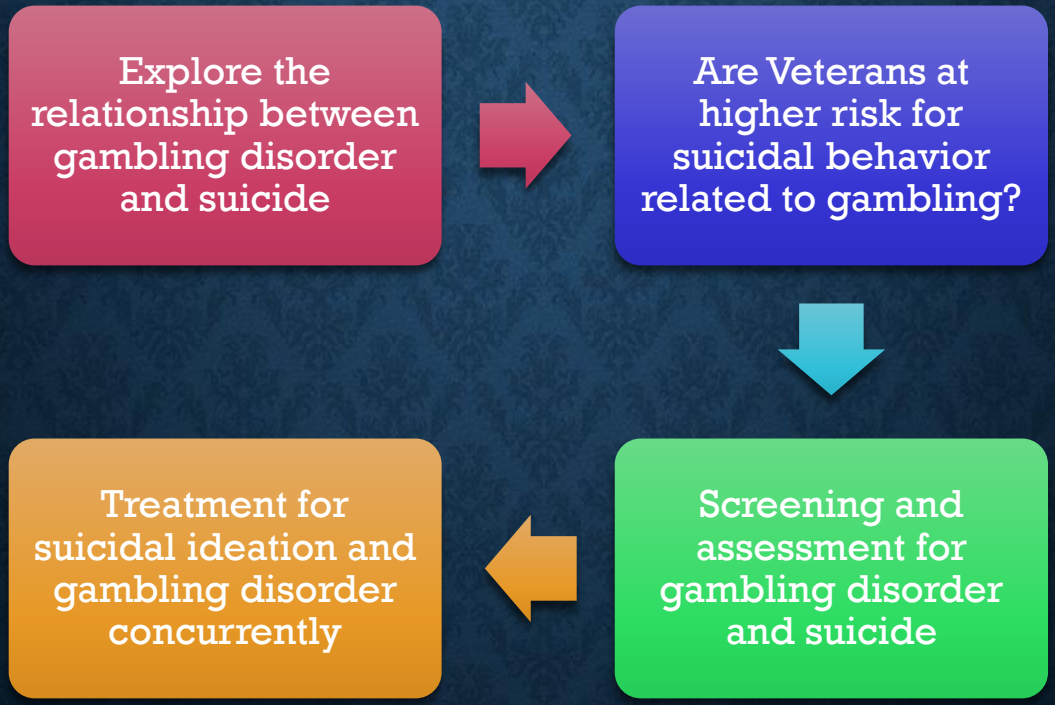
The impulsive urge to escape negative emotions can override future plans. No-suicide contracts/safety contracts have very little evidence that they work. Ongoing assessment of suicidal ideation/intent is necessary.

MYTH OR FACT??

If someone truly wants to die by suicide, there is really nothing you can do about it.

Suicidal crisis is often time-limited. If you can help an individual to get through the immediate crisis, can save a life and allow further treatment.

OVERVIEW


Explore the relationship between gambling disorder and suicide
Are Veterans at higher risk for suicidal behavior related to gambling?
Screening and assessment for gambling disorder and suicide
Treatment for suicidal ideation and gambling disorder concurrently

GAMBLING DISORDER PREVALENCE (SLUTSKE ET AL., 2012)

Up to 90% of the U.S. adult population gamble in their lifetime

Problem gambling in 2-5 % of U.S. adults

10% of military Veterans

Lifetime gambling disorder in 1-2% of U.S. adults

2-3% of military Veterans (Stefanovics et al., 2017)

4.2% of OEF/OIF/OND Veterans (Whiting et al., 2016)- higher rates of TBI may impact impulsivity, increased access

GAMBLING DISORDER IN VETERANS

42.95 % gambled in past year; 4.2% likely had gambling disorder (Whiting et al., 2016)

Deployment environment and general harassment while deployed related to probable pathological gambling

- Not when depression was controlled for

Post-deployment stress predictive of gambling disorder

Social support had negative relationship with gambling disorder

SUICIDALITY IN GAMBLING DISORDER

Wong et al., 2014

- 1/2 of disordered gamblers experience suicidal ideation
- 1/5 of disordered gamblers attempt suicide

Ronzitti et al., 2019: Treatment-seeking gamblers

- 17-48% for suicidal ideation
- 9.7-31% for suicide attempts

PREDICTORS OF SUICIDALITY IN GAMBLING DISORDER

Financial debt is best predictor of suicide attempt amongst individuals with gambling disorder (Wright, 2012)

- Up to ½ of attempts have significant debt (Paul, Wong, et al., 2014)

Women, unemployed, low income, young/old, Loss of job , Relationship issue, Death of significant other, Medical problems

(Bischof et al., 2015, 2016; Komoto, 2014; Thon et al, 2015)

Mental Health Disorders and Personality Traits may also contribute to suicide risk

MH PREDICTORS OF SUICIDALITY IN GAMBLING DISORDER

- Comorbid psychiatric conditions
  - Mood Disorders (Petry and Kiluk, 2002)
  - Depression (Maccallum and Blaszczynki, 2003)
  - Anxiety (Black et al., 2015)
  - Substance Use Disorder (Bischof et al., 2015; Hodgins et al., 2006; Kim et al., 2016; Ledgerwood et al., 2005)
  - Cluster B Personality Traits (Bischof et al., 2015)
- Some disorders may predict SA, while others predict SI (Joiner 2005; Klonsky and May, 2010; O'Connor 2011)
  - Panic disorder, impulsivity and suicide attempts

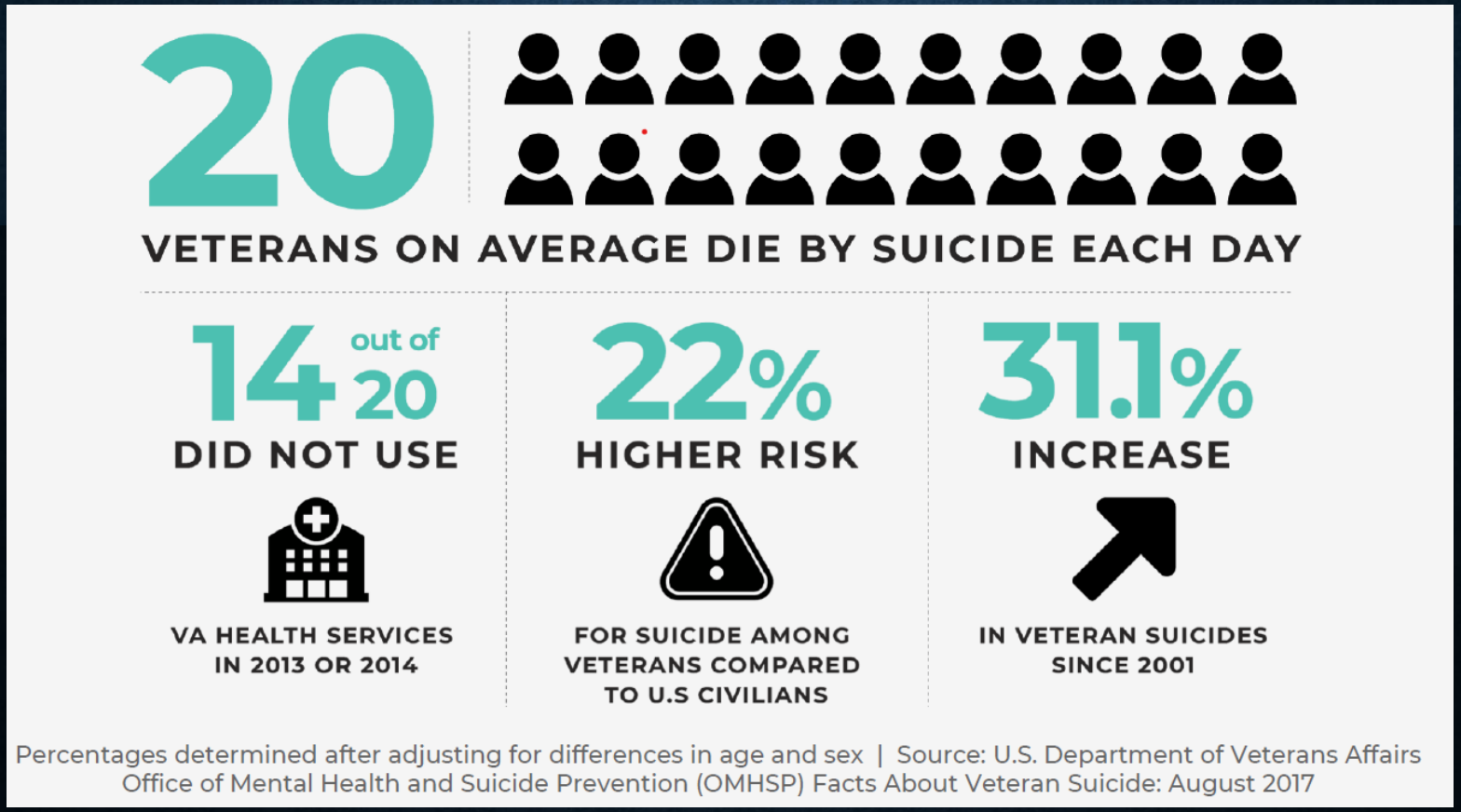
MODELING SUICIDALITY IN GAMBLING DISORDER (RONZITTI ET AL., 2019)

- Examined whether suicidality served as moderator between problem gambling severity and psychiatric disorders
  - Gambling severity was associated with increased risk of suicidality and psychiatric disorders (SEM)
  - Results suggested that overall, factors other than Axis I disorders influence relation between suicidality levels and problem gambling

PERSONALITY AND MENTAL HEALTH (MALLORQUI-BAGUE ET AL., 2018)

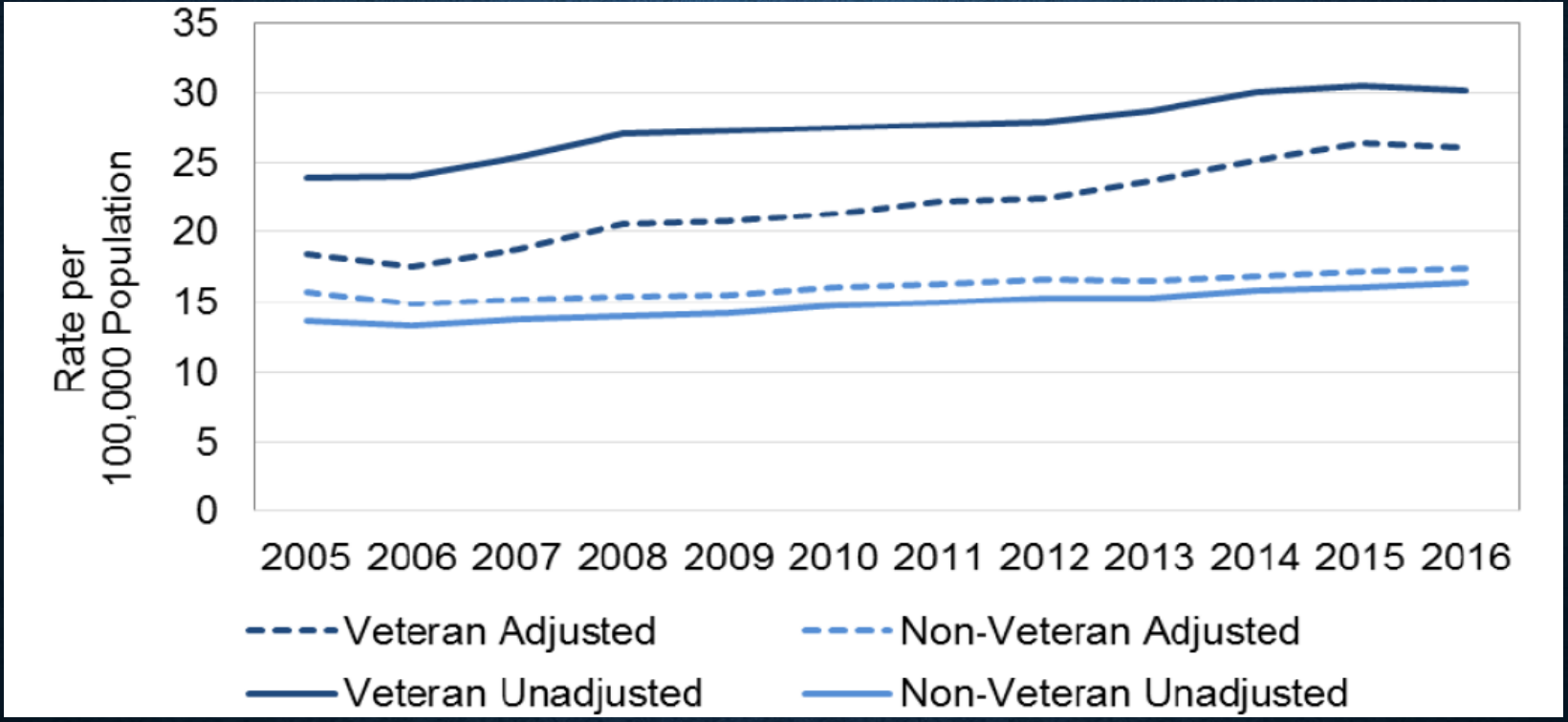
- Impulsivity and emotion dysregulation may predict suicidal ideation in gamblers
- Psychopathology and GD severity predicted suicidality
  - High trait impulsivity and emotion dysregulation indirectly predicted GD severity
- Suicidal ideation directly predicted suicide attempts

SUICIDALITY IN VETERAN POPULATION

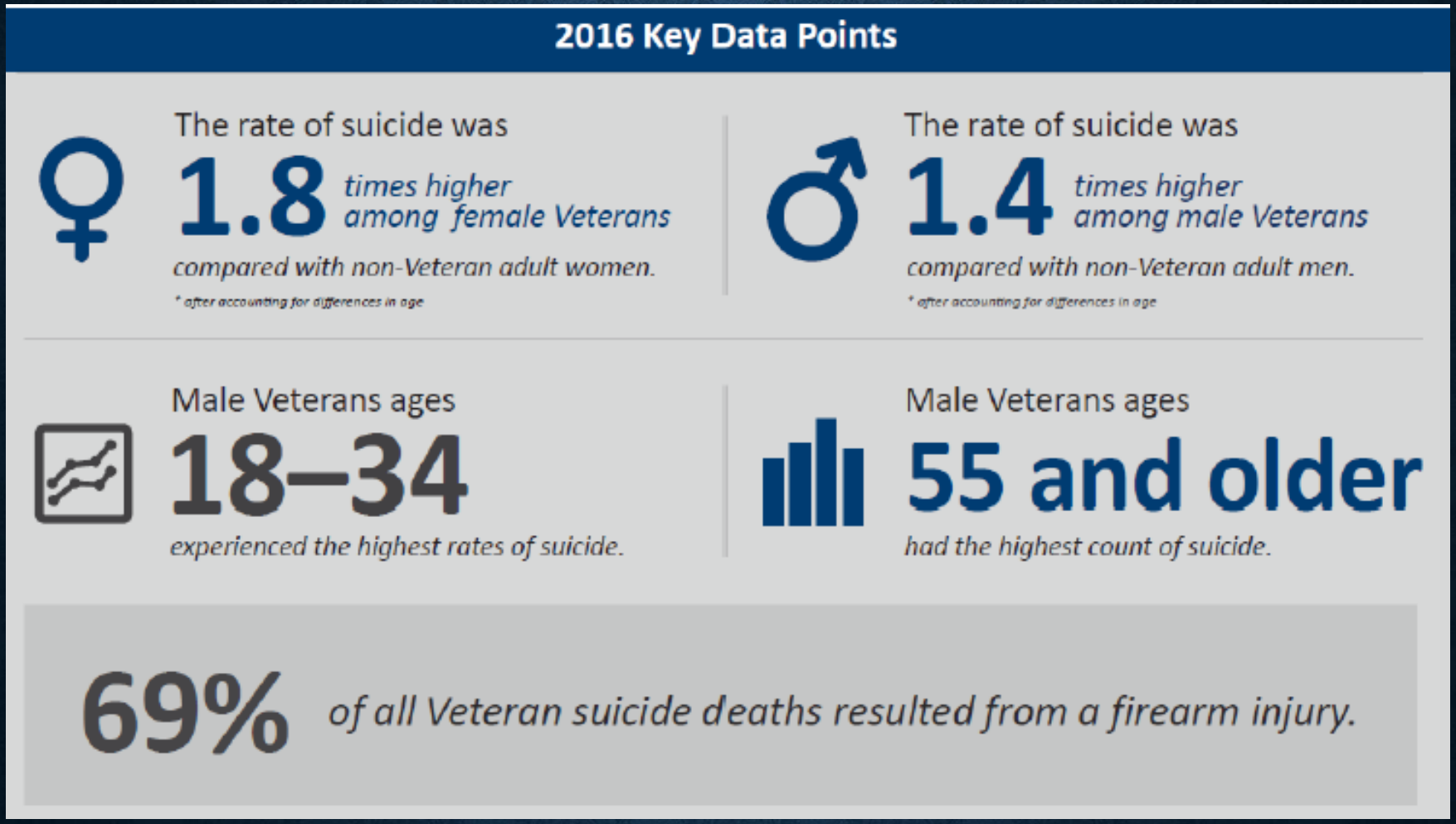


# of combat deployments, OTH discharge status, increased time in service, and previous suicide attempts increase risk

SUICIDALITY IN VETERAN POPULATION



(Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention, 2016).



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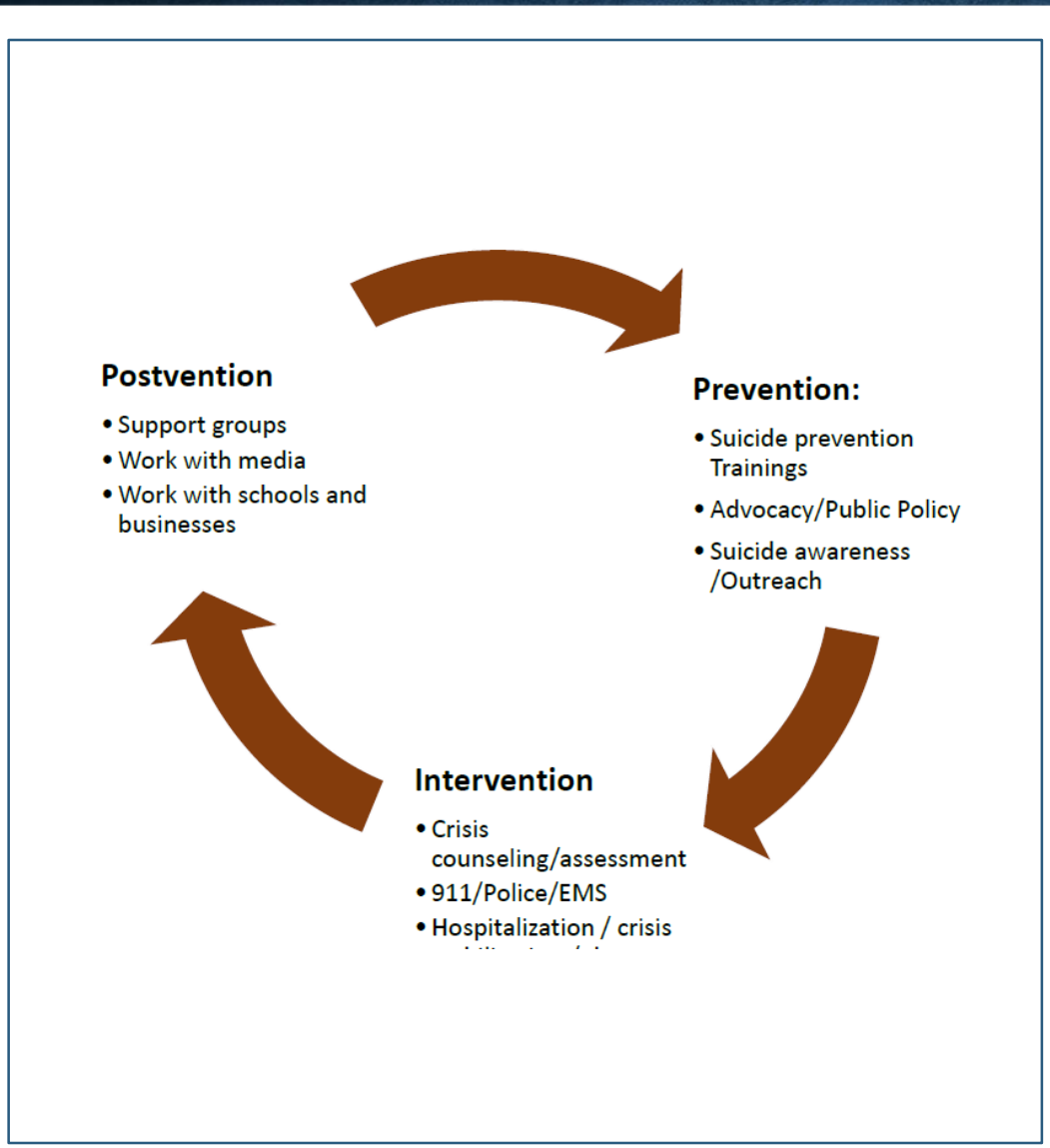
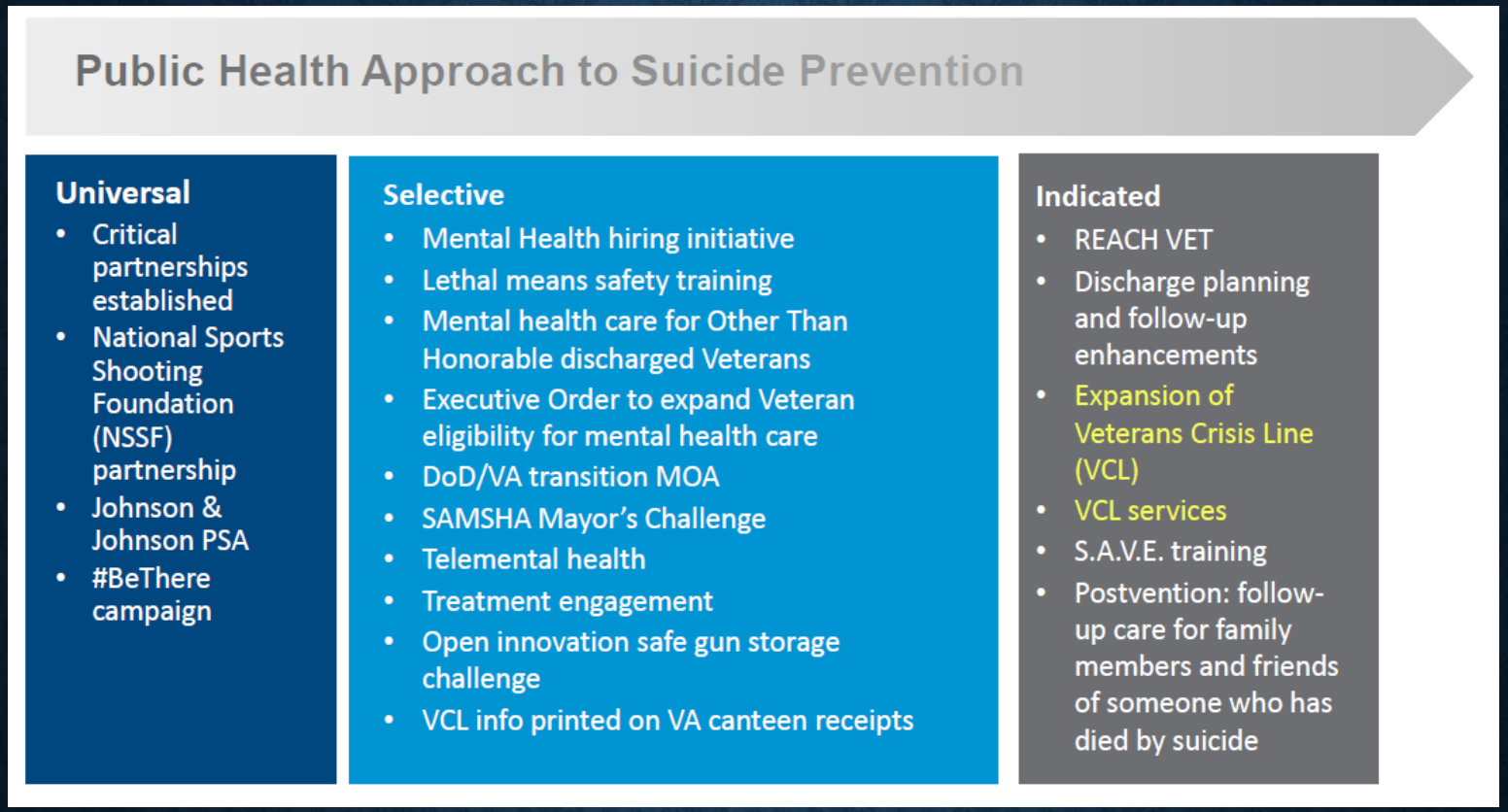
COMBINING PUBLIC HEALTH AND CLINICAL INTERVENTIONS





PUBLIC HEALTH APPROACH TO PREVENTION (MILLER, BRITTON, & MCCARTHY, 2019)

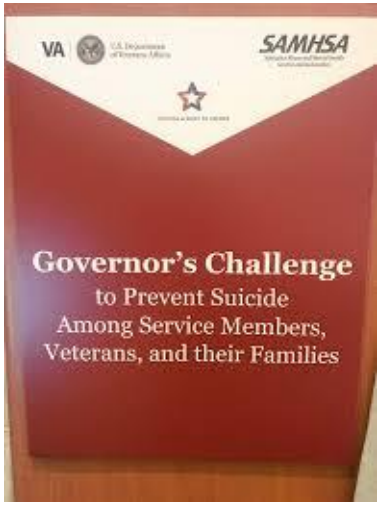
- The majority of Veterans are not connected to VA services, so we must find innovative strategies to serve Veterans who do not – and may never – seek care, benefits or services from the VA system.
- This requires a community level effort that engages stakeholders to work together towards ending Veteran suicide, including:
  - Health care systems
  - Veterans and Military Service Organizations
  - Faith communities
  - Higher learning
  - Law enforcement and criminal justice
  - Employment
  - Community service
  - Nonprofits and nongovernmental organizations
  - Media and entertainment
  - Private sector industries
  - Public-private partnerships
  - Federal, state and local government

PUBLIC HEALTH APPROACH

BE CONNECTED ARIZONA (WRIGHT, DOMINICK, WINKEL, 2019)

- Goal is early intervention to impact social determinants of health before a crisis
- PREVENTS executive order signed into law in March 2019 to increase connectedness between VA/DOD and community partners

EXAMPLES OF PUBLIC HEALTH APPROACHES TO SUICIDE PREVENTION FOR VETERANS



- Technology/social media campaigns: #BETHERE, Veterans Crisis Line, Maketheconnection.org, Togetherwecan (for Vets, caregivers, families)
- Critical Incident Training (CIT) for law enforcement and first responders
- Governor's/Mayor's Challenge Workgroups
- Peer support training/NAMI initiatives
- VA/DOD chaplains trained in suicide prevention via Mental Health Integration
    - ACT, MI, Problem Solving Trainings for chaplains

SCREENING FOR SUICIDE RISK

A BRIEF PRIMER ON TERMINOLOGY (FROM VA/DOD CLINICAL PRACTICE GUIDELINES FOR SUICIDE PREVENTION)

Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself with evidence, whether implicit or explicit, of suicidal intent.
Suicide	Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.
Suicide Attempt	A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior.
Preparatory Behavior	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).
Suicidal Intent	There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and inferred in the absence of suicidal behavior.
Suicidal Ideation	Thoughts of engaging in suicide-related behavior. (Various degrees of frequency, intensity, and duration.)
Interrupted By Self or Other	A person takes steps to injure self but is stopped by self or another person prior to fatal injury. The interruption may occur at any point.
Physical Injury	A bodily injury resulting from the physical or toxic effects of a self-directed violent act interacting with the body.

Developed in collaboration with the Centers for Disease Control and Prevention

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9) KROENKE, SPITZER & WILLIAMS, 2001

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

COLUMBIA SUICIDE SEVERITY RATING SCALE (C-SSRS)

- Semi-structured clinical interview, with a standardized set of core questions
- Assesses a range of ideation
  - Passive, Active, Method, Intent, Plan
- Intensity & Severity of ideation:
  - Frequency, Duration, Controllability, Deterrents, Reasons
- Behavior subgroups:
  - Actual, Interrupted, and Aborted Attempts, Preparatory Behavior
  - Lethality of attempts (including potential lethality)

Ilgen, 2019; Rocky Mountain MIRECC (Britton, Pope, Madden, 2019)

COLUMBIA SUICIDE SEVERITY RATING SCALE (C-SSRS) SCREENER

	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, answer questions 3, 4, 5 and 6 If **NO** to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Any **YES** indicates the need for further care. However, if the answer to **4, 5** or **6** is **YES**, **immediately ESCORT** to Emergency Personnel for care, **call 1-800-273-8255, text 741741** or **call 911**.

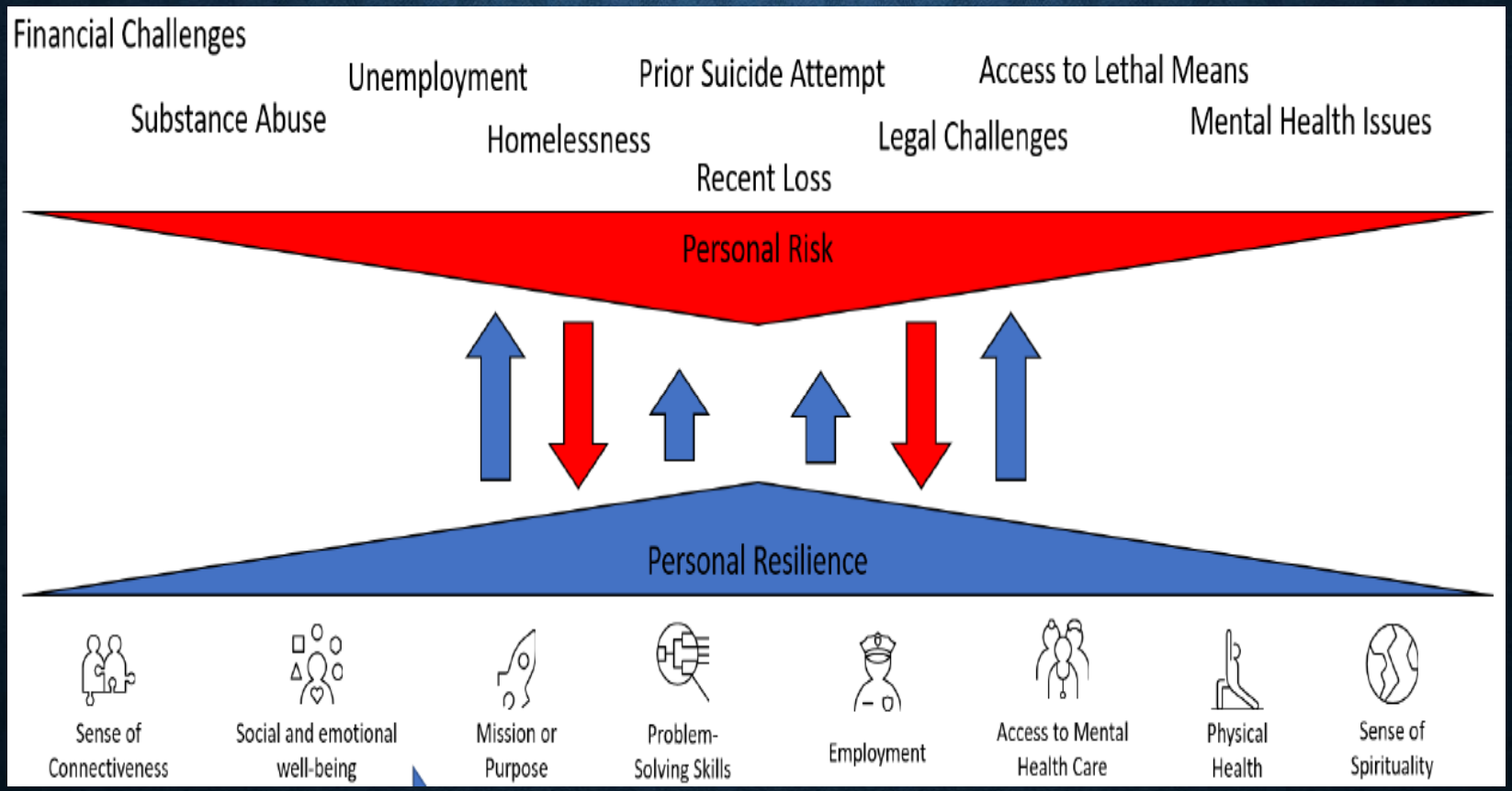
DON'T LEAVE THE PERSON ALONE. STAY WITH THEM UNTIL THEY ARE IN THE CARE OF PROFESSIONAL HELP

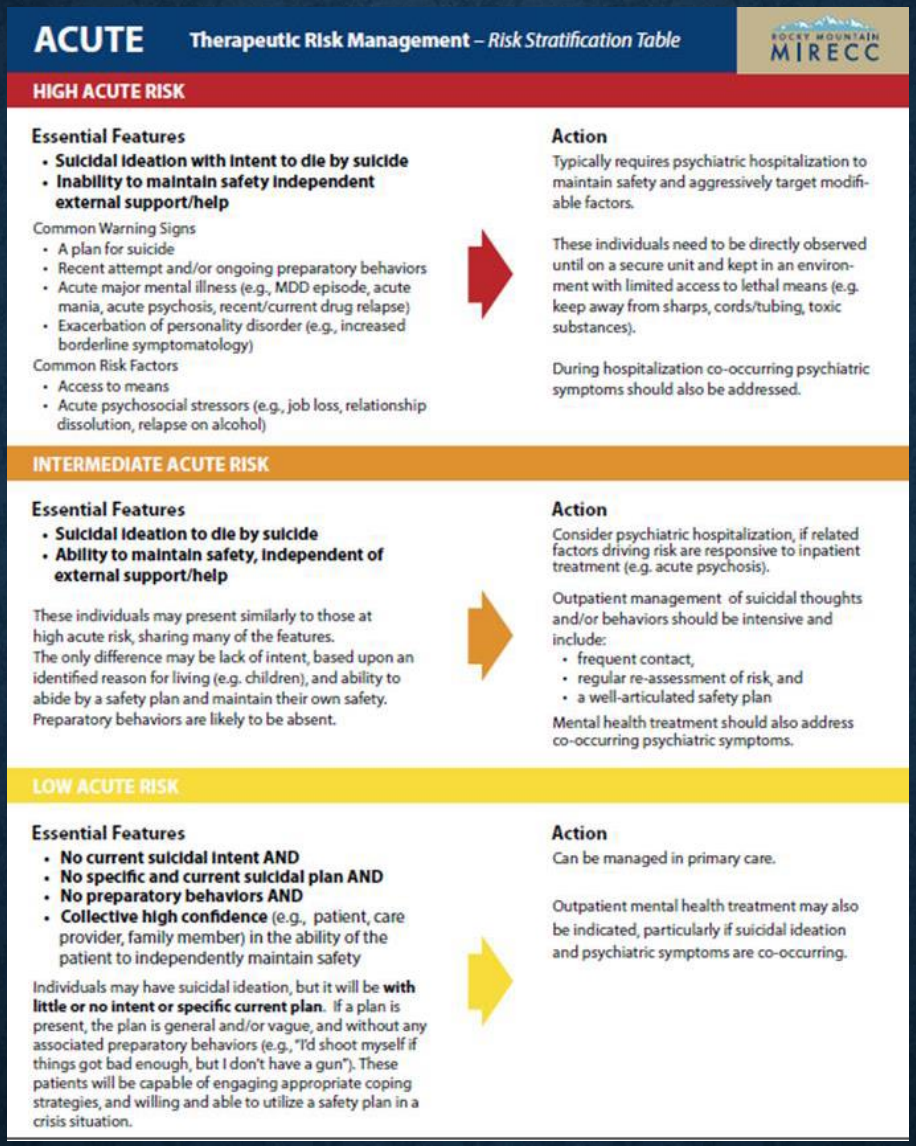
THE COLUMBIA LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

SUICIDE RISK ASSESSMENT

- DOD/VA Clinical Practice Guidelines recommend an assessment of risk factors
  - Current suicidal ideation, prior suicide attempt(s), current psychiatric conditions (e.g., mood disorders, substance use disorders, gambling) or symptoms (e.g., hopelessness, insomnia, agitation), prior psychiatric hospitalization, recent bio-psychosocial stressors, and the availability of firearms/ means
- We're still not great at assessing risk (false positives/false negatives)
  - More information collected increases specificity of treatment plan
- Predictive Analytics via assessments with neural networking and AI (VOI Reach: Hudenko, 2018)
  - Low cost, better prediction, saves time
  - Implemented in VA via REACH Vet

RISK AND PROTECTIVE FACTORS GRIT: VA/DOD SUICIDE PREVENTION CONFERENCE, 2019





SUICIDE RISK STRATIFICATION ROCKY MOUNTAIN MIRECC, 2019

VOLUNTARY HOSPITALIZATION AND INVOLUNTARY COMMITMENT

Honestly discuss limits to confidentiality at onset with new patient

Many reluctant to disclose due to previous interactions with clinicians

Know your local policies before a crisis

IVC, coordination, transportation, resources, post-discharge followup

If hospitalization is warranted, discuss your local processes openly and honestly

Discuss goal of stabilization, safety planning, medication initiation, and/or treatment planning

INITIAL SAFETY PLANNING FOR HIGH RISK PATIENTS

Developing a Safety Plan

Steps at a Glance

Step 1: Recognize Warning Signs

What are the specific thoughts, emotions, behaviors, or sensations that indicate a crisis is occurring or escalating?

Step 2: Plan Internal Coping Strategies

What are some coping strategies that can distract from suicidal thinking? Examples include going for a walk, exercising, or listening to inspirational music.

Step 3: Identify Social Contacts and Environments That May Distract From the Crisis

What social contacts or environments can provide a distraction if the coping strategies in Step 2 do not resolve the crisis? Example contacts include a friend, faith leader, or support group.

Step 4: Identify Family Members or Friends Who Can Help

What family members or friends can be contacted if the strategies in Step 3 do not resolve the crisis? If the Veteran discloses having no family or friend support, consider other interventions to address social isolation, like social skills training, peer support, and group therapy.

Step 5: Determine Professionals and Agencies to Contact for Help

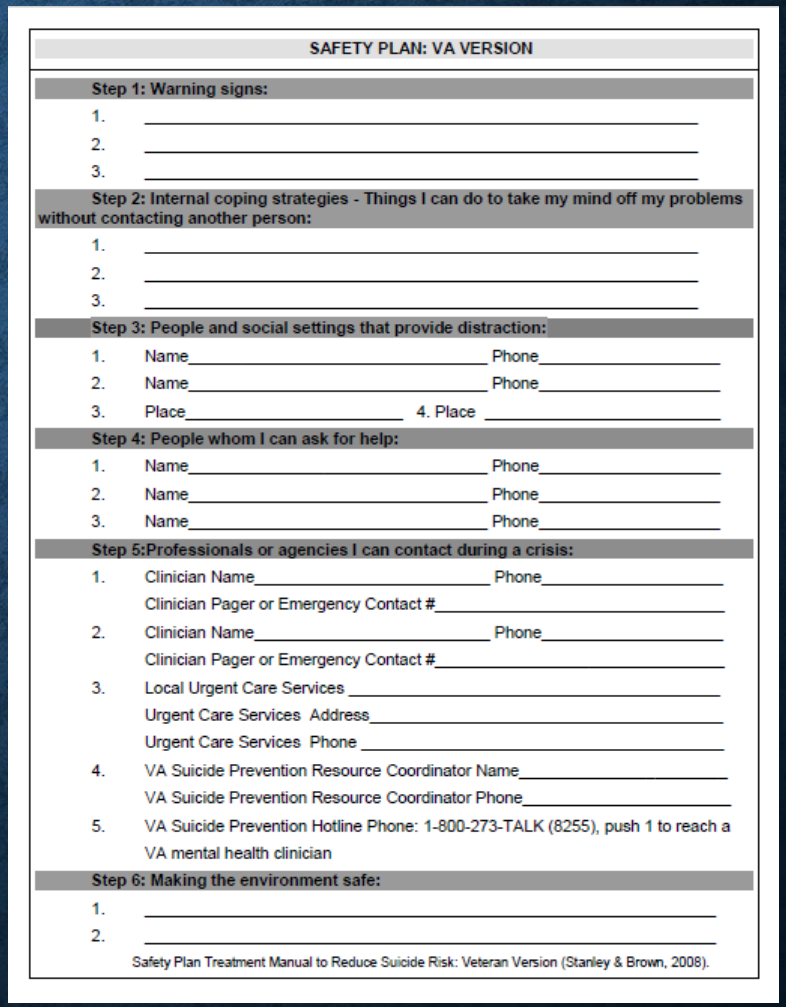
What professionals or professional services, such as mental health and primary care providers, can be contacted for help?

Step 6: Create a Safe Environment

Has the Veteran thought of a suicide method or developed a specific suicide plan? For any method that has been identified, determine the Veteran's access to the lethal means and make a plan to reduce that access.

If you or someone you know is in crisis, call the Veterans Crisis Line at **1-800-273-8255 and Press 1**, chat online at **VeteransCrisisLine.net**, or text **838255**.

U.S. Department of Veterans Affairs



SAFETY PLAN: VA VERSION

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. VA Suicide Prevention Resource Coordinator Name_____
   VA Suicide Prevention Resource Coordinator Phone_____
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

Very little evidence for alternative “safety contracts”

A NOTE ABOUT LIMITING MEANS

- Limiting means should be tailored to potential plan if expressed
- Firearms (gun locks, storing in safe [giving others code/key], storing ammunition separately, removing ammunition from home, out of home storage, use of technology)
- Medication (pill boxes, medication "take-back" programs [local/ postal], family member dosing, naloxone, discussing accidental overdoses)
- Removing other means (e.g. rope, piping, any preparatory devices)
- Avoidance of locale associated with method (e.g. bridge, road barriers)

SAFETY PLANNING WILL OFTEN INFORM TREATMENT PLAN

Identifies patient's level of insight into warning signs/triggers

- Assess relation between gambling/SUD triggers

Identifies current coping skills or lack thereof

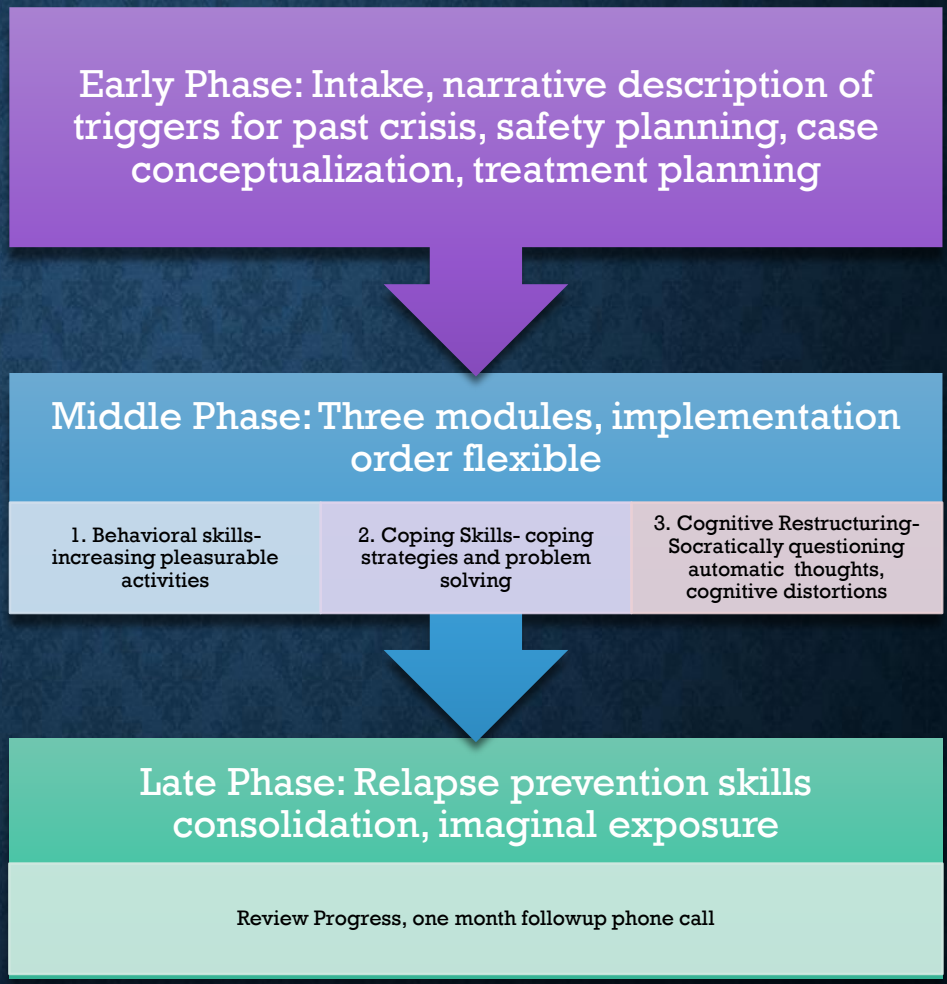
- Emotional identification often lacking
- Basic psychoeducation often needed related to emotions

Highlights current social support system

Natural start for CBT for Suicide Prevention

COGNITIVE BEHAVIORAL THERAPY FOR SUICIDE PREVENTION CBT-SP

(BROWN, 2017 ORIGINAL; ADAPTED TO TELEHEALTH BY ILGEN, OLSON-MADDEN, LINDENAUER, 2019)



3 Cs Practice

Step 1 – **CATCH IT** 	• When you notice a change in your mood or become upset, then ask yourself: • **What am I thinking about right now?**
Step 2 – **CHECK IT** 	• What is the evidence **for** the thought? • What is the evidence **against** the thought? • **Is it completely true?**
IF NO, THEN Step 3 –**CHANGE IT** 	• **What is a more truthful or more helpful thought?**

Adapted from *Group Cognitive Behavioral Social Skills Training (CBSST) Manual* (Granholm et al., 2005) and McQuaid et al. (2000) by Gregory K. Brown, Ph.D. and Dimitri Perivoiltis, Ph.D

BRIEF COGNITIVE BEHAVIORAL THERAPY FOR SP (BCBT: RUDD, 2015)

- Three Phases:
- Identify triggers and teach basic emotion regulation strategies (5 sessions)
- Cognitive restructuring for high risk thoughts (5 sessions)
- Relapse prevention with imaginal exposure to previous triggers (2 sessions)

Section A (*Patient*):

Rate and fill out each item according to how you feel right now.

Rank Then rank items in order of importance 1 to 5 (1= most important to 5= least importanc

Rank	
2	1) **Rate psychological pain** *(hurt, anguish, or misery in your mind; **not** stress; **not** physical pain):* Low pain: 1 2 3 4 (5) :High pain What I find most painful is: *no job, isolated*
4	2) **Rate stress** *(your general feeling of being pressured or overwhelmed):* Low stress: 1 2 3 (4) 5 :High stress What I find most stressful is: *uncertain about future*
5	3) **Rate agitation** *(emotional urgency; feeling that you need to take action, **not** irritation; **not** annoyance):* Low agitation: 1 2 (3) 4 5 :High agitation I most need to take action when: *at night, when I go to bed*
1	4) **Rate hopelessness** *(your expectation that things will not get better no matter what you do):* Low hopelessness: 1 2 3 4 (5) :High hopelessness I am most hopeless about: *everything, things never work out for me*
3	5) **Rate self-hate** *(your general feeling of disliking yourself; having no self-esteem; having no self-respect):* Low self-hate: 1 2 3 (4) 5 :High self-hate What I hate most about myself is: *being lost – again*
N/A	6) **Rate overall risk of suicide:** Extremely low risk: (will not kill self) 1 2 (3) 4 5 :Extremely high risk: (will kill self)

1) How much is being suicidal related to thoughts and feelings about yourself?

Not at all: 1 2 3 4 (5) :Completely

1) How much is being suicidal related to thoughts and feelings about others?

Not at all: (1) 2 3 4 5 :Completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
3	*my intelligence*	2	*things never work out*
1	*a good job*	1	*can't take the pain*
2	*finding someone to love*	3	*won't find healthy relationsh*
4	*my brother*	4	*I hate myself like this*

I wish to live to the following extent:

Not at all: 1 2 3 (4) 5 6 7 8 :Very much

I wish to die to the following extent:

Not at all: 1 2 3 (4) 5 6 7 8 :Very much

The one thing that would help me no longer feel suicidal would be:
to find a job and a good relationship

COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY GROUP (JOBES ET AL., 2012; GUTIERREZ ET AL. 2019)

- Group facilitation for suicide prevention may be as effective as individual interventions
- 6 cumulative phases
  - Identification of risks
  - Collaborative assessment via Suicide Status Form
  - Collaborative treatment planning
  - Tracking suicide status over time
  - Resolution of suicide status
  - Relapse Prevention

INTEGRATING GAMBLING DISORDER TREATMENT INTO CBT FOR SUICIDE PREVENTION

Assess the role of gambling in suicidal ideation or previous attempts

- Is gambling a warning sign on the safety plan?
- Chasing losses, debt, big wins, cognitive distortions
- Impact of gambling on self-esteem, helplessness, hopelessness
- Is gambling identified as coping skill/ distraction on safety plan?
  - Attempt to provide psychoeducation and identify alternatives

Integrative gambling-related cognitions into cognitive restructuring and treatment plan

- "I'll win enough back so that my wife won't leave me"
- ''I've lost a lot the last five times, so I'm due a big win"
- "I'll never be able to get out of debt. Suicide is my only option."

Suicide Prevention and Recovery Care Group (SPARC: Yahney & Ambrose, 2019)

May serve as model for SP group in gambling disorder

Safety planning, identification of relapse triggers, coping skills

EMOTIONAL REGULATION & CONTEXTUAL INTERVENTIONS FOR SUICIDAL BEHAVIOR

- Goal of suicide may be to **escape unwanted** emotions, thoughts, and/or physical sensations (i.e., **internal experience**) and related unwanted external experiences *(Barnes et al., 2017)*
    - "Suicide results from persistent and escalating attempts to succeed at an **unworkable agenda of internal control"**
- ACT for LIFE (Barnes et al., 2017) or DBT approaches may serve to allow alternative means of emotion regulation
    - destigmatize suicidal ideation and urges (they're part of the dysfunctional control agenda)
    - promote mindfulness of suicidal triggers and increase capacity to respond flexibly
    - "directly target ***functional recovery*** by assisting patients in identifying and engaging in value-consistent behaviors despite associated aversive thoughts, emotions, or sensations"
    - Three modules delivered individually over the course of 3 to 6 sessions.
- Skills Training in Affective and Interpersonal Regulation (Cloitre et al., 2002)
- DBT for emotional regulation skills- weak evidence for general suicide prevention
    - may be more effective in gamblers, due to impulsivity and emotion dysregulation difficulties

LESSONS LEARNED FROM GROUP FACILITATION OF CBT-SP

- Create a safe space to discuss suicide without fear of commitment
  - First time many are actually allowed to discuss in front of peers
- Many are disappointed they've survived attempts
  - Allow group processing
- Encourage discussion of precursors to previous attempts
- Psychoeducation about emotional identification may be needed before introduction of coping skills/ grounding
  - Blend of treatment modalities often needed
- Limit conversation about specifics of means in group format
  - Avoid glamorizing past/future attempts
- Hospitalization is not a failure (It's using their safety plan!)
- Allow a few repeaters (limit size of group)
- Encourage sharing of contact information
- Prepare for postvention ahead of time
- Safety planning is ongoing and "It's ok to copy eachother's answers"

PHARMACOLOGICAL INTERVENTIONS FOR SUICIDE VA/DOD CLINICAL PRACTICE GUIDELINES, 2019

- Weak evidence for ketamine with comorbid Major Depression
- Weak evidence for lithium in bipolar disorder, and lithium + other agents for Major Depression
- Weak evidence for clozapine in schizophrenia or schizoaffective disorder

OTHER PROMISING INTERVENTIONS FOR SUICIDE PREVENTION IN VETERANS

Caring Contacts

- Sending suicidal patients brief, non-demanding expressions of care and concern at specified intervals over a year or more
- Significant reductions in suicide deaths, attempts, and ideation at one and two-year follow-up
- Improve care during the critical transition following discharge

Landes, 2019

Veterans upload photos, videos, reasons for living from friends/family, as well as preloaded material.
VHB users reported significantly greater ability to cope with unpleasant emotions and thoughts (Bush et al., 2016)
May be useful technology-driven adjunct to safety plan

CLINICAL POSTVENTION AFTER A COMPLETED SUICIDE

- Suicide survivors may be more at risk for complicated bereavement, psychiatric disorders, and may also be at greater risk for suicide themselves –contagion (see Jordan & McMenamy, 2004 for review; Survivors of suicide task force, 2015; Nazem, 2019)
- Important to accurately assess emotions associated with loss
  - Grief/loss vs. fear/trauma
  - Dominant emotion may help to tailor treatment plan
- Assess for suicide risk with survivors (friends and family of deceased)
- Trauma should be dealt with prior to grief processing (Springer et al., 2018)

POSTVENTION GUIDING PRINCIPLES (SPRINGER ET AL., 2018; FRENCH AND MCGEE, 2019)

- Avoid simplifying causes of suicide
- Discourage a focus on the method of suicide
- Highlight correlation between suicide and mental health conditions as well as treatment availability. Address stigma of mental health conditions.
- Avoid romanticizing or glamorizing the deceased.
- Provide a structure that facilitates ongoing prevention efforts.

POSTVENTION AND POST TRAUMATIC GROWTH

- •Tragedy Assistance Program for Survivors (TAPS) : 3 phases
- Ensure stabilization/make referrals for treatment, process grief and adopt grief rhythm, move toward post-traumatic growth

- Post traumatic growth after suicide (French and McGee, 2019)
  - Survivors explore ways to make meaning of the loss
  - Help survivors tell their story in a way that restores hope
  - Shift from the focus on how one died to how one lived, honor legacy
  - Establish a new relationship with the deceased
  - Help survivors live their own life to the fullest

EXAMPLES OF TAPS RESOURCES FOR BEREAVED SURVIVORS (RUOCCO & SPRINGER, 2019)

- Access to peer based support and care 24/7/365.
- Case assistance with federal, state and local benefits.
- Resource Kit with grief materials to help cope.
- Connection with free grief support and counseling referrals.
- Individualized community-based resource report.
- Trained Peer Mentor for personal support.
- Lifetime subscription to *TAPS Magazine* with articles on coping and healing.
- Invitations and access to regional/national support programs.
- Access to emergency financial assistance.
- Anniversary and holiday cards.
- eNewsletters offering inspiration.
- Online community including chat rooms, blogs, list serves, social networking.

TAKEAWAYS

- Suicidal ideation and attempts are more common in the Veteran population, especially when gambling disorder is present
- Prevention, crisis intervention, and postvention are all important components of a comprehensive prevention effort
- Screening for suicide should occur at all intakes, and followup assessment should be conducted when appropriate
- CBT interventions for suicide prevention have the most empirical evidence
  - Individual or group
  - Safety planning, emotion regulation, cognitive restructuring
- Know, utilize, and provide the available resources that are out there!

THANK YOU!

QUESTIONS